

Name: _____

Phone #: (____) _____ Resident #: _____

Address: _____

City: _____ State: ____ Zip: _____

General

1. Individual's Name:

2. Address:

3. Phone:

4. County:

5. Guardian:

6. Guardian Address:

7. Guardian Phone:

8. Type of Service:

9. Service & Support Administrator:

10. Service Span:

11. Homemaker/Personal Care Provider:

12. Other Service Providers:

13. Date(s) of Review:

14. Date of Last QA Review:

Comments:

15. Information for this review was obtained from the following sources:

16. The QA process was explained to the following individual:

17. This occurred on the following date:

Comments:

18. He/she gave consent to the Clearwater COG to complete a QA review of the services and consent to send a copy of the report to the parties listed. Signature on file.

Individual Choices and Options

1. The individual has the opportunity to make or is assisted in making choices about all aspects affecting his/her life.

Choose One: Yes - Y, No - N

Comments:

2. Chooses where he/she lives and with whom.

Choose One: Yes - Y, No - N

Comments:

3. Chooses daily work and leisure routine.

Choose One: Yes - Y, No - N

Comments:

4. Did the individual choose their daily representative?

Choose One: Yes - Y, No - N

Comments:

5. The individual demonstrates an understanding of his/her rights.

Choose One: Yes - Y, No - N

Comments:

6. The individual has the space and opportunity for privacy. (I.E.: has own bedroom, if roommate: chose & gets along with roommate, can be alone when wants to)

Choose One: Yes - Y, No - N

Comments:

7. The home where the individual lives has rules he/she is required to follow. (I.E.: regarding eating schedule, TV time, and when has to go to bed) Explain.

Choose One: Yes - Y, No - N

Comments:

8. The individual owns and is able to use personal possessions.

Choose One: Yes - Y, No - N

Comments:

9. Does anyone take your things without asking? What happens? Who would you tell? Who takes your things?

Choose One: Yes - Y, No - N

Comments:

10. When appropriate, the individual has the opportunity to utilize adaptations and technological or communicative assistance. (Has individual asked for something they have not received?)

Choose One: Yes - Y, No - N

Comments:

Community Membership

1. People important to the individual (list individuals)

2. The individual is able, with assistance if necessary, to communicate by correspondence, the telephone, or visits with any person who is meaningful and supportive to the individual.

Choose One: Yes - Y, No - N

Comments:

3. The individual has the opportunity for relationships with friends and peers that provide companionship and support. (Do they get to visit them?)

Choose One: Yes - Y, No - N

Comments:

4. The individual has the choice and opportunities to engage in activities where interactions with Non-disabled people may occur.

Choose One: Yes - Y, No - N

Comments:

5. The individual has opportunities to practice ethnic and religious customs and beliefs of his/her choice.

Choose One: Yes - Y, No - N

Comments:

6. The individual is informed about community resources and generic services and is assisted in accessing needed services.

Choose One: Yes - Y, No - N

Comments:

7. The individual has access to support options through unpaid sources such as neighbors, family and friends.

Choose One: Yes - Y, No - N

Comments:

8. As interested, the individual is supported in activities such as voting, attending community meetings, writing letters to political figures, serving on committees and/or boards, and participating in self-advocacy groups.

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

Health

1. The individual receives prompt and appropriate medical and dental treatment, monitoring of medical services, and appropriate medications as needed.

Choose One: Yes - Y, No - N

Comments:

2. The individual receives prompt treatment for physical and/or psychological problems and is informed/encouraged and supported to receive such treatment.

Choose One: Yes - Y, No - N

Comments:

3. The individual's health is maintained through safe behavior.

Choose One: Yes - Y, No - N

Comments:

4. The individual's challenging behaviors are supported in a positive way.

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

5. The individual takes their medications as prescribed.

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

6. The individual is provided with adequate food choices to maintain health through nutrition.

Choose One: Yes - Y, No - N

Comments:

7. The individual is provided opportunities for exercise in an effort to maintain health.

Choose One: Yes - Y, No - N

Comments:

8. Self Administration Assessment

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

9. DSMIV if on psychotropic medication

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

Every Healthy Person

1. Annual Health Examination

Choose One: Yes - Y, No - N

Comments:

2. Annual Dental Examination

Choose One: Yes - Y, No - N

Comments:

3. Mammography

Ages 40-49, every 1-2 years - As ordered by Physician

Ages 50-69 - Annual

Ages 70+ - Annual as Ordered by Physician

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

4. Cervical Cancer Pap Smear

Ages 19-64 - Every 1-3 years as Ordered by Physician

Age 65+ - As ordered by Physician

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

5. Colorectal Cancer Screen

Ages 50+ - Annual Fecal Blood Test & Sigmoidoscopy

Every 5 years or Colonoscopy Every 10 years

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

6. Prostate Cancer Screen

Age 50+ - As Ordered by Physician

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

Additional information regarding Every Healthy person can be obtained from odmrdd.state.oh.us.

7. Medical Appointments

8. Current Medications

Housing

1. The individual's residence has the basic furnishings and provisions necessary for daily living activities: e.g., food preparation and eating, sleeping, bathing and living.

Choose One: Yes - Y, No - N

Comments:

2. The individual resides in a home that is located in the community in a manner convenient to services, such as stores, banks, places of entertainment, places of worship and transportation. The house blends in with the neighborhood.

Choose One: Yes - Y, No - N

Comments:

3. The individual resides in a residence where both the interior and exterior are maintained in a manner that promotes basic safety and health.

Choose One: Yes - Y, No - N

Comments:

4. The individual exercises choice and control over the selection of furnishing and decor. The individual has possessions and decorations selected by him/her that are evident in the residence.

Choose One: Yes - Y, No - N

Comments:

Personal Income

1. The individual has a stable source of income that covers basic living needs including, but not limited to, shelter, basic utility services, food, transportation, and clothing.

Choose One: Yes - Y, No - N

Comments:

2. Income is effectively managed to ensure that basic needs are met.

Choose One: Yes - Y, No - N

Comments:

3. The individual participates as fully as possible in decision making about the use of his personal income through the development of money and budgeting concepts and values that encourage financial responsibility.

Choose One: Yes - Y, No - N

Comments:

4. Cash on hand.

5. Checking account balance.

6. Savings account balance.

Personal Satisfaction

1. The individual is satisfied with the activities, services, and supports in which he is assisted to complete. (The individual wants to modify/change their services. There are services that the individual is receiving that are no longer wanted or needed by the individual. There are services the individual doesn't like.)

Choose One: Yes - Y, No - N

Comments:

2. The individual is satisfied with the interactions with the staff/others who provide support.

Choose One: Yes - Y, No - N

Comments:

3. The individual has a choice in their provider staff that work with them and knows how to change staff.

Choose One: Yes - Y, No - N

Comments:

4. Individuals experience continuity and security.

Choose One: Yes - Y, No - N

Comments:

5. The individual feels that the support staff helps him/her with everyday activities.

Choose One: Yes - Y, No - N

Comments:

6. The individual feels people are mean to them.

Instructions/Documentation Required: If so, what happens? Who would you tell? Who is mean?

Choose One: Yes - Y, No - N

Comments:

7. The individual feels that the county board and service provider(s) listens to, responds and respects his/her choices for services, supports and activities. (Are there additional services or supports the individual feels they need from the County Board.)

Choose One: Yes - Y, No - N

Comments:

8. The individual feels that they are respected by their staff. (I.E.: Staff says Please and Thank you.)

Choose One: Yes - Y, No - N

Comments:

9. The individual understands they have a choice about what is in their ISP.

Choose One: Yes - Y, No - N

Comments:

10. The individual understands they can set a long term or life goal and work toward it.

Choose One: Yes - Y, No - N

Comments:

11. The individual understands there is a provider pool to choose from including adult day services.

Choose One: Yes - Y, No - N

Comments:

12. The services in the ISP are being updated as the individual grows.

Instructions/Documentation Required: Compare the previous year's ISP to current; are there any changes?

Choose One: Yes - Y, No - N

Comments:

13. The individual is making progress. If not; why (barriers)

Instructions/Documentation Required: Look over the past 1 - 2 years to see if any skills developments have changed.

Choose One: Yes - Y, No - N

Comments:

14. There are services the individual doesn't like.

Choose One: Yes - Y, No - N

Comments:

15. There are additional services or supports the individual feels they need from the County Board.

Choose One: Yes - Y, No - N

Comments:

16. The individual knows who to contact if they are dissatisfied or have any complaints.

Choose One: Yes - Y, No - N

Comments:

Safety

1. Potential dangers in the individual's environment are minimized.

Choose One: Yes - Y, No - N

Comments:

2. The individual's home is maintained and supports are in place allowing the individual to feel safe within the home. If they don't, these issues are being addressed.

Choose One: Yes - Y, No - N

Comments:

3. Individual has access to prompt and appropriate emergency and other needed services.

Choose One: Yes - Y, No - N

Comments:

4. The individual is free of abuse, neglect, injury and exploitation.

Choose One: Yes - Y, No - N

Comments:

Residential Provider

1. 5123:2-9-05 Effective 9/30/05 Residential provider documentation included the following for the month of:

2. Name of individual and their Medicaid number.

Choose One: Yes - Y, No - N

Comments:

3. Name of provider and their 7 digit provider number.

Choose One: Yes - Y, No - N

Comments:

4. Type of service

Instructions/Documentation Required: Daily Rate = N/A

Choose One: Yes - Y, No - N

Comments:

5. Date of service

Choose One: Yes - Y, No - N

Comments:

6. Place of service

Choose One: Yes - Y, No - N

Comments:

7. Signature or initials of person delivering the service

Choose One: Yes - Y, No - N

Comments:

8. Number of units delivered or continuous amount of uninterrupted time during which the service was provided.

Instructions/Documentation Required: Adult Foster Care & Daily Rate = N/A

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

9. Includes arrival and departure times

Instructions/Documentation Required: Adult Foster Care & Daily Rate = N/A

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

10. Group Size

Instructions/Documentation Required: Daily Rate = N/A

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

11. Description and details of the services provided that relate to the ISP.

Choose One: Yes - Y, No - N

Comments:

12. Includes monthly statement regarding the individual's response to their services

Instructions/Documentation Required: Adult Foster Care & Daily Rate = N/A

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

13. The individual received the services as identified in the ISP.

Choose One: Yes - Y, No - N

Comments:

14. ISP and BSP (if appropriate) in the home

Choose One: Yes - Y, No - N

Comments:

15. Billing History checked

Choose One: Yes - Y, No - N

Comments:

16. Provider had documentation to support the billing

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

17. Provider works to match staff to the individual.

Instructions/Documentation Required: Adult Foster Care = N/A

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

18. How has the provider specifically matched the staff to the individual?

Instructions/Documentation Required: Adult Foster Care = N/A

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

19. Does the provider agency have an office in the individual's home?

Instructions/Documentation Required: Adult Foster Care = N/A

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

20. Does the individual have access to to all areas in their home at all times?

Choose One: Yes - Y, No - N

Comments:

Narrative

Individual Services

1. What is the individual trying to achieve (dream/goals); (What are they trying to achieve as outcomes? Are there services in the ISP to address the targeted outcomes?)

2. What is important to the individual?

3. For non verbal individuals...how do the provider/MRDD agencies know what is important to the individual?

4. What is the individual's satisfaction regarding their movement toward increasing skills, living more independently in the community, accessing community services, increasing feelings of self worth, and increase in choice making? Do you feel you are in control of your life?

Monitoring

5. If there are issues discovered during monitoring or past QA reviews was there follow up to change or correct issues?

Observations

6. Are staff interactions positive during review? People are treated as people first. Communication occurs among people, their support staff, and their families.

Positive Outcomes

7. (Describe)

Individual Satisfaction

1. Satisfaction With Services:
Choose One: Yes - Y, No - N
Comments:

2. Satisfaction with Provider:

Choose One: Yes - Y, No - N

Comments:

3. Satisfaction With Living Environment:

Choose One: Yes - Y, No - N

Comments:

Guardian Satisfaction

1. Satisfaction With Services:

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

2. Satisfaction with Provider:

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

3. Satisfaction With Living Environment:

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

Service Areas to Improve

For the Provider:

1. Recommendations for quality improvement:

2. Recommendations for the Provider that warrant SSA Follow-up.

Choose an answer in the range 0 to 25

Comments:

For the Service and Support Administrator:

3. Recommendations for quality improvement:

4. Quality Improvement Plan (QIP) Indicated for the SSA:

Choose an answer in the range 0 to 25

Comments:

5. Quality Improvement Plan due to Clearwater COG by:

Comments:

For the ISP Team

6. Additional recommendations for the ISP Team to Consider:

Comments:

Signatures

1. Quality Assurance Report prepared by:

2. Date:

3. cc:
